

<b>Case Number:</b>	CM14-0011410		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	10/31/2003
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	01/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 61-year-old with a January 31, 2003 date of injury. A specific mechanism of injury was not described. The January 23, 2013 determination was non-certified given no physical exam findings for the necessary criteria and no conservative treatment rendered to the knee. January 14, 2014 procedure report identifies that a trochanteric injection was performed. There are no subjective or objective findings documented. An October 28, 2013 medical report identifies low back pain radiating to the left leg, left hip, and left knee; as well as right hip. The patient has undergone epidural injections, massage, medication, physical therapy, and rest. Exam revealed decreased sensation over the right L4 and L5 distribution with 4/5 right knee extension and dorsiflexion. The left knee was tender to palpation over the lateral retinaculum, medial facet, and medial retinaculum.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**One left knee injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Rheumatology Guidelines, ACR Criteria Section.

**MAXIMUS guideline:** Decision based on the MTUS Knee Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 13), pages 339 and 346, as well as the Non-MTUS Official Disability Guidelines (ODG), Knee and Leg Chapter.

**Decision rationale:** The patient appears to have lumbar radiculopathy. It is not entirely clear if the knee pain is related to the lumbar radiculopathy or has a pathology involving the knee joint. The subjective findings include back pain radiating to the left lower extremity, including the knee, yet, on physical examination only the right side presented neurological disturbances. It is also not clear if any of the conservative modalities previously performed were specifically directed to the left knee. There is no effusion described. In addition, the most recent knee exam only included tenderness. There is no described weight bearing views describing arthritis. There is insufficient documentation to substantiate the necessity of a knee injection. The request for one left knee injection is not medically necessary or appropriate.